

HEROIN AND OPIOID EMERGENCY TASK FORCE MEETING

November 4, 2015, 1:15PM-4:23PM
Wineland Building, 16 Francis Street, Annapolis, MD

MEMBERS ATTENDING

Lt. Governor Rutherford
Dr. Michael Finegan
Senator Katherine Klausmeier
Nancy Dudley
Dr. Bankole Johnson
Linda Williams
Sheriff Tim Cameron
Judge Julie Solt
Delegate Brett Wilson
Tracey Myers-Preston

INTRODUCTION

- **Lieutenant Governor:** we don't know how many recommendations we're going to propose in terms of numbers. We must understand realities in terms of budget implications. Some recommendations are legislative in nature, and we have to work with the legislature on what they will agree to and how it's done.
- Led motion to approve the minutes from the last meeting, which was moved and seconded.

UPDATES/RECOMMENDATIONS (Led by Lt. Governor)

DHMH/PDMP

- I'd like to see mandatory registration and query. Phased approach; waiting for more of DHMH's recommendations and suggestions that they'll be sending in. We have to move in that direction.
 - o **Dr. Finegan:** PDMP must be commented on in our final report because it's so important.
 - o **Lt. Governor:** It is going to be a recommendation, based on what we are going to get back from DHMH. This is something to be done fairly quickly.
 - o **Richard Tabuteau:** We anticipate legislation this session on this.
 - o **Dr. Finegan:** Yes, and a roadmap is needed too, which will show that the Task Force is doing something.

PREVENTION & OUTREACH PROGRAMS

- **Lt. Governor:** This includes needle exchange programs. Because of the increase in Hepatitis C and HIV, locals can make their own determinations. We've talked about online education regarding Naloxone as part of the overdose response program. In the recommendations, there was also a lot of focus on more public awareness about Good Samaritan laws.
- **Dr. Finegan:** There needs to be legislation to provide more clarity. There is a lack of clarity on pre-trial release and probation on parole.

- **Lt. Governor:** This can be part of the recommendation.
- **Dr. Finegan:** It was Steve Kroll's opinion that there needs to be greater clarification.
- **Linda Williams:** more clarity is needed; it's not clear to many.
- **Lt. Governor:** If you can provide gunshot victim information, why not overdose information – in real time?
- **Dr. Finegan:** There needs to be additional clarification on reporting based on the quantity of illegal drugs. There needs to be criteria: when is it too much?
 - **Chris Shank:** That volume wouldn't be covered; it's only possession for Good Samaritan, not trafficking.
 - **Dr. Finegan:** We must educate law enforcement on this point.
 - **Ms. Williams:** We recommend that we must clarify and educate everyone on what the law is.

ACCESS TO BUPRENORPHINE

- **Dr. Finegan:** Having standalone doctors giving buprenorphine creates a problem. People just want the pill and no other treatment. Every physician who gets the waiver may not provide a link to treatment. This may create a bigger problem.
- **Tracey Myers-Preston:** We want to link to counseling, but we should not separate medication as though it's not part of treatment.
- **Dr. Finegan:** we have problems right now with programs that are just giving pills.
 - **Dr. Johnson:** I support that. We need to give social support along with medication, or else it's not treatment. It's dangerous because it tends to lead to diversion and the entrenchment of the disease where people take medication for long periods of time – it's then harder to get them off. Whole families become involved in taking opiates because they were just handed tablets and medication. I wouldn't say medication alone is the standard of care for treatment.
 - **Ms. Myers-Preston:** I support that; apologies because there's a lot of anti-medication dialogue, we should speak positively about it.
 - **Dr. Johnson:** psychological treatment without medication alone is also poor treatment. The reason is there's a lot of very good data showing that relapse rates from psycho treatment alone are very high: 80-90% over 6-month period. Medication alone is 50%. Combined together, you can sustain treatment rates of closer to 50-55% in most individuals. Having one and not the other is weak treatment and not the standard of care.
- **Lt. Governor:** DHMH recommendations: increase authorized and willing providers and integrating them with treatment. It doesn't have to be publicly funded in my mind, although that is what DHMH recommends. They *are* talking about an integrated approach.
- **Ms. Williams:** this cannot be a cookie-cutter approach; it's an individual, holistic approach that's needed.
 - **Dr. Johnson:** Must be personalized in a structured system. There must be a standard of treatment, and within that, you can tailor what the individual needs.
 - **Ms. Williams:** That's what I'm saying.
 - **Dr. Finegan:** This is a system problem, not a doctor problem.
 - **Ms. Myers-Preston:** Sometimes it's a doctor problem.

- **Dr. Finegan:** Yes, true.
- **Dr. Johnson:** Treatment must be more integrated. There's no reason for it to be separated. This is missing in a lot of the materials we reviewed.
 - **Brett Wilson:** Are there legal barriers to this?
 - **Dr. Johnson:** No.
 - **Dr. Finegan:** There are financial disincentives.

RECOVERY SUPPORT SPECIALISTS AND PREGNANCY

- **Lt. Governor:** Asking BHA to pilot recovery support program to work with women during pregnancy (women suffering with substance abuse disorder). We have to look a little closer in terms of budgetary impact on this one. Interim recommendations talk a little bit about some money to pilot efforts to help women with children. This one would be in the pregnancy stage, though.
- **Dr. Finegan:** Our workgroup collected data on this through the criminal justice system and pulling that survey data to make recommendations of things to be addressed. That's in our workgroup's recommendations.
- **Ms. Williams:** There is a team together to start a program to get women before Medicaid kicks in so they can start treatment immediately.
- **Dr. Finegan:** In Southeastern Maryland, out of 87 pregnant females addicted to opiates, only 40 attended care. When using birth control to stop recurrent pregnancy, only 1 out of 10 of those women who gave birth to opiate-exposed newborns were subsequently on birth control. We have to incentivize or disincentivize stronger. There are recommendations there on data. Effectively, the idea is out there but it's not occurring.

DHR's RECOMMENDATION OF COMPREHENSIVE SCREENING AT INTAKE

- **Lt. Governor:** This should and could be done. DHR touches a lot of people in the public. They want to implement inter-agency case management system. The challenge is the HIPAA issues and what they can exchange and can get from DHMH or someone else, but people can agree to provide it – as long as they don't feel like it will threaten their benefits.

MULTI-JURISDICTIONAL INVESTIGATIVE UNIT FOR HEROIN

- **Lt. Governor:** State police suggested creating multi-jurisdictional state police investigative unit for heroin, working with high-intensity drug trafficking program. For the most part it would be a statewide effort. In some jurisdictions we have some integration with state and local police but they want to formalize this a little bit more. State police also recommended designating HIDTA as central repository for Maryland drug intelligence. Similar to Sheriff Cameron's recommendations.
 - **Sheriff Cameron:** State and local data may diverge due to overdose reporting.

ENHANCING INTERDICTION OF DRUG-LADEN PARCELS

- **Lt. Governor:** Working with postal inspectors.
- **Dr. Finegan:** This was brought up to us by a lower-level state trooper at the Hagerstown summit. There's a massive problem.

DAY REPORTING CENTERS

- **Lt. Governor:** GOCCP talked about establishing day reporting centers as a pilot process program for drug treatment. Pennsylvania has this. This is worth taking a look at for ex-offenders who still need the support and services.

TREATMENT ON DEMAND

- **Lt. Governor:** We're trying to investigate treatment on demand: how to really address that. We've had some conversations with Health Facilities Association of Maryland (HFAM) – old nursing homes – and they're interested in providing facilities. There's more capacity in rural centers. If they have personnel, this might be something to look into. Not sure if this will be ready as part of the report, but it may be a solution for something on demand. There was a recommendation about Massachusetts's police department where people can go there and say they have a problem and ask to be put in jail or hospital.
- **Ms. Myers-Preston:** Treatment on demand approach got a lot of resistance. Lack of integration in Maryland is hard; on the mental health side, we have a lot of these things. A lot of money is given to jurisdictions and they can spend how they want, which leads to a lot of variability. We can repurpose what we have. There is a way to build an integrated system where mandate and funding isn't separated. There are dollars and a way to do this; we just have to have a mandate that requires certain things to be offered. The best model for crisis intervention is in Virginia.

SAFE STREETS INITIATIVE

- **Lt. Governor:** The Safe Streets Initiative is geared towards high-crime areas and is an integrated approach. Chris's group talked about focusing more on substance abuse side of it.

MISCELLANEOUS RECOMMENDATIONS

- Dr. Finegan had recommended taking a closer look at the correctional officers' bill of rights for swifter adjudication of issues. We saw that with the men's detention center – real challenges there with smuggling contraband.
- DJS recommend enhancing intake questions and screening for substance abuse disorders for kids coming into their system.

INFORMATION SHARING & OVERDOSE RESPONSE

- **Sheriff Tim Cameron**
 - o Establish a hub in consultation with chiefs, sheriffs, GOCCP. HIDTA should be the hub for all heroin tracking and overdose data. We are asking to see funding analysts for intelligence centers to track case information and also nexus of overdose to dealers. We have information that can be queried. Local intelligence centers are doing this – this can be made statewide. Overdose information will lead back to supplier.
 - o Establish a training program for law enforcement.
 - o Interdiction strategies – expand them based on intelligence. This would require examination of strategies that are out there, and a look at our training and levels of

our interdiction. Multi-jurisdictional task force approach allows you to pool resources. One of the most effective strategies is attacking the monetary aspect of the organizations that supply and move drugs.

- Utilize existing Task Force and partnerships. Chiefs and sheriffs are wary of working with task forces.
- Expand funding under GOCCP's Safe Streets – either in overtime money or more people.
- Strengthen PDMP – we recommend mandatory PDMP.
- Look at legislative initiatives and effect of removing mandatory minimums. Create Maryland law similar to federal legislation so we can go after those who distribute heroin or fentanyl that result in death. Something similar to RICO statute.
- More money for drug take-backs. Drop boxes are hugely successful. This comes part and parcel with public education. These prevent diversion.
- Hospitals: we do fatality reviews on all fatality cases. We should look at them on overdoses. We need leverage to do this – ability to request information.

- **Ms. Myers-Preston**

- The most important thing is that we need a full network analysis done because we don't know where we are spending the dollars. We have problems with jurisdictions offering variability. We should be able to get the same level of care wherever we are in the state. There's a lot of evidence we are overspending on residential treatment. This system redesigned would go hand in hand with incentive program. Capacity is always tied to reimbursement. How can there be good care if there's no funding?
- SBIRT in schools – we have a great program and funding with that; the plan should be to expand, and get SBIRT in the ER.
- Support overdose education online – it's much too cumbersome right now. Current training does not talk about some of the universal precautions for injectables.
- ASAM criteria needed

INSURANCE

- **Ms. Myers-Preston**

- Medical necessity should be decided by treatment providers, not insurance.
- Medicaid regulations include telehealth but not substance abuse. We need parity.
- Mental health should be carved in as part of an integrated system. We need to start working on this process now.
- MIA – so many barriers – we need to give people more access. Most treatment delivered in Maryland is through a program.

SYRINGE EXCHANGE PROGRAM, FAMILIES

- **Dr Finegan**

- Syringe exchange program – idea of increasing amount of needles on the street. Minimize barriers and maximize distribution. Have document from those dealing with this in Baltimore City.
- A lot are low-hanging fruit that can be easily put in place.

- Parents are not involved across the state. They don't come to treatment or facilitate it. We have to find a way to tell them that they must be an essential part of their addicted child's treatment. Research reflects that we're trying to keep the family together and not taking the kids out of the home.

POLICE DIVERSION PROGRAMS

- Dr. Finegan

- Police diversion programs: talked to Gloucester (MA), Seattle, programs that are working – helping to change the view of “us versus them” with law enforcement and public; provides a help and is easy to do in Maryland. Someone can come in to a police department and ask for help, and that law enforcement officer can take that individual to a treatment center.
 - **Mr. Tabuteau:** Isn't the problem more about capacity rather than police officers not wanting to help?
 - **Lt. Governor:** Do people with substance abuse problems go to the police to tell them they have a problem? Don't they go to hospitals?
 - **Dr. Johnson:** Wait for our report, and we will answer that question. There are a hundred myths about substance abuse treatment. A myth is that residential treatment is necessary; this is not supported by research. The best treatment for addicts is some kind of step-down, intensive, outpatient facility or a place where they can go during the day to get treatment. This is all that research shows. If we divert, we are going against the evidence for treatment. The issue being raised is we can't treat enough people in an inpatient program; it's wasteful as well. We must provide treatments – police, hospitals, wide range of other people can access. That's really what's needed.
 - **Mr. Tabuteau:** Do we have enough outpatient facilities?
 - **Dr. Johnson:** Yes, we do, but not in the way it is framed currently. We have enough facilities and services. We have the places but they don't work in the way they should.
 - **Ms. Myers-Preston:** We are funding the most expensive level of care and treatment determinations are determined by what is available. It is a broken system.
 - **Dr. Johnson:** The problem that we have is that the knowledge is 2015 and the practice is 1960. There is no relationship between severity of patient and the intensity of the needed treatment. There is a lot of medicine where experience is not the best teacher of what should happen to a patient. You cannot grade every treatment by severity.
 - **Dr. Finegan, to Lt. Governor:** Go to Hopkins NICU: see how many parents are there – there are so few. We want mothers to take care, but they are not.
- Giving incarcerated inmates treatment only in a short period of time before their release is not good.
- Establish recovery units at corrections facilities – ECI system should be piloted at other facilities.

- **Mr. Tabuteau:** Did wardens say that there are people who can serve as peer recovery in these places?
- **Dr. Finegan:** Yes.

MARYLAND CENTER FOR EXCELLENCE

- **Dr. Johnson**

- If you boil it down, we have one recommendation. This is a recommendation based on: the need to unify strategy to coordinate treatment efforts across the board; implementation of meaningful standards; to ensure what treatment dollars are buying and what outcomes we are getting from them. Establish a Maryland Center for Excellence to do all this.
- High-level board of governors, multidisciplinary.
- This is not just an academic institution with theories.
- At this point we don't have enough information to make strong decisions.
 - **Ms. Myers-Preston:** We have already adopted a definition and framework. We're just not living it out.
- We need discipline and following metrics and algorithms. It is not going to be solved by anything else. Do some of this, and we can save some lives.
 - **Ms. Dudley:** One of the major challenges would be coordinating law enforcement and treatment. If this were to be coordinated through GOCCP, for example, a lot of that would be in place. This center would touch the treatment prevention issue and law enforcement – it would be a good vehicle to follow through recommendations.
- **Mr. Tabuteau:** In order to attract these people, do you think a board of directors would be paid or unpaid?
 - **Dr. Johnson:** These should not be paid positions, they should be like us, who have volunteered. There are people who want to solve the problem. Directors being paid would create conflict. It's a way that great minds get a chance to continue the Task Force work and implement what comes out of this report. This is to do with implementation and getting things done.
- **Mr. Tabuteau:** Is the cost and way to reduce the cost – housing this in a university – is that necessary if the board is presumably Ph.D-type people? Because my sense is if you put this in a university, they'll want all sorts of staff and stuff that we'll have to pay for. Could it go directly to GOCCP without being housed in university? Cut out a layer.
 - **Dr. Johnson:** The problem doing this is that it would no longer be independent and able to be a true forum of bringing together ideas that may be in some ways a little bit unpopular for the folks involved. As for cost, universities are very capable of negotiating with the Governor and Lt. Governor! This is not a way for the university to make any money. This is to protect the independence of the group, to allow group to work well and to do true data analysis. You really need to have this in an academic institution.
 - **Lt. Governor:** The university will say it needs money.
 - **Dr. Johnson:** We will handle that. I give you my word that I will make sure that does not happen.

- **Lt. Governor:** By shifting it to GOCCP, that's not GOCCP's mission. The point is, this is a medical issue; a disease. GOCCP is law enforcement.
- **Dr. Johnson:** The final recommendation for funding is at the Governor's discretion. The group that does this must pay for itself over time – produce savings to justify its budget.
 - **Mr. Tabuteau:** Is there evidence at the federal level? Like X cost this much but saved government Y amount of money.
 - **Ms. Dudley:** I don't think so, but the more coordination there is at the top, the better outcomes you're going to have. The ultimate implementation would be a much more refined, scaled, specific mission. You could have a liaison to GOCCP who can focus on law enforcement.
- **Dr. Johnson:** A lot of states have done this and they have been very effective.
- **Ms. Dudley:** This is an attempt to coordinate.
- **Dr. Finegan:** Volunteerism is a luxury.
- **Senator Klausmeier:** You can have a board of directors, but it's a great recommendation that we explore different ways to do it. We can't figure out the nuances here.

EDUCATION/PUBLIC AWARENESS

- Linda Williams

- Focus on prevention – making them feel good in the beginning – refusal skills, decisionmaking skills. They're not always taught at home. Gives children positive attitudes – utilize school resource officers to get trained in DARE. Positive image of police officer is a good thing.
- After-school activities: kids that don't have after school activities. i.e. homework program, art, sports, etc. are 49% more likely to use drugs.
- Senator and I met with Councilman Shreve: Frederick is pursuing film festival. Hopefully this can be done next year statewide. Hopefully the Lt. Governor will support this.
 - **Senator Klausmeier:** You can ask MSDE to support this.
- Collegiate centers have dorms of students that are especially drug-free or are in post-treatment; abstinence, drug-free dorm for whatever reason.
- We should have Social workers who do SBIRT in schools, although this is a school decision.
- Spread public awareness through a user-friendly school website. I've talked to lots of parents, and they say they would love it – even parents of toddlers.
- Launch a big public campaign – PSAs, adding more info each year.
- Develop larger campaign advertising the Good Samaritan law.
- Develop clearinghouse; the Maryland Center for School Safety can be clearinghouse where people can go get PSAs, different information and share it.
- Provide training on addiction with all professions that have to do with addiction. Most people don't understand it.
- Develop strategies with workforce. It costs a lot of money to have employees who are addicted. Educate businesses about what addiction is and why treatment center is needed, but also get the treatment centers to be better neighbors – be considerate of businesses around them.

- **Senator Klausmeier:** We have to look at this per county because zoning restrictions differ.
- Get involved with faith-based communities.
- Support teen courts.
- Peer recovery coaches need to play a larger role – need to be used in communities that aren't in the criminal justice system yet.
 - **Ms. Myers-Preston:** Look at funding for peer recovery coaches. It costs \$16,000 to train apiece.

REENTRY AND DRUG COURTS

- **Brett Wilson**
 - Have been working with JRI.
 - Vivitrol pilot programs – maintain funding while we build data to see whether they are effective in overall treatment.
 - Health Article 8-505, 8-507 program is a reentry designated program to maintain current funding or improve funding as dollars become available. Right now there is a 5-month delay from time judge signs order transferring from 8-505 to 8-507 treatment because of backlog.
 - GOCCP and Pew Research developing framework for day report center.
 - **Comment from audience:** day report centers usually have a step-down program. At first it's daily, and as you progress, you step down to a few days a week. It's a model and depends on your progress.
 - **Dr. Finegan:** I want to convey a strategy here: we need to recognize that we have to look at partial, not full, successes. What we can achieve and what is most important to achieve. Get the public and legislators behind this. To do that, we need powerful figures: Lt. Governor, Governor, Task Force people – to speak out in powerful ways. This topic is going to catch fire even more in the next few months. Start there. This is creating a vision for the legislature and the public – it has to come from our leadership. Get people motivated. Use basic human values – protecting innocent children. Secondly, focus on where we get most bang for the buck. PDMP, Naloxone program will save the most lives short-term. Needle exchange program, not as powerful. Level 2 is law enforcement component of idea of vast majority of heroin coming in through mail system and facilitating interdiction will have the most bang for the buck. At Level 3 is that we have to change the quality of care in this state.
- **Lt. Governor:** On November 4 of last year, the Governor and I were elected. We listened to the state and found out how pervasive heroin was – we were surprised. We wanted to do this as one of the first things in our administration.
- **Ms. Myers-Preston, Ms. Williams:** You were the first who has listened to us.